SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Filing at a Glance

Company: John Hancock Life Insurance Company

Product Name: Leading Edge - 5% Compound/EEP	SERFF Tr Num: MULF-126047669	State: ArkansasLH
TOI: LTC03I Individual Long Term Care	SERFF Status: Closed	State Tr Num: 41708
Sub-TOI: LTC03I.001 Qualified	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form/Rate	Co Status:	Reviewer(s): Marie Bennett
	Authors: Joanne Witham, Richard Famiglietti, Pat Hamlett	Disposition Date: 03/12/2009
	Date Submitted: 02/24/2009	Disposition Status: Approved-Closed
Implementation Date Requested: 07/01/2009		Implementation Date:

State Filing Description:

General Information

Project Name:	Status of Filing in Domicile: Pending
Project Number:	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 03/12/2009	Explanation for Other Group Market Type:
	State Status Changed: 03/12/2009
Deemer Date:	Corresponding Filing Tracking Number:

Filing Description:

Re: John Hancock Life Insurance Company

Company NAIC # 65099, FEIN # 04-1414660

Individual Long-Term Care Insurance Forms & Rate Submission

Endorsements Forms for Policy Form LTC-06 AR

(See attached Forms List)

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Dear Commissioner:

We enclose copies of the forms listed above for your review and approval. A description of these forms is found below. These forms are new and will replace any prior versions that we currently have on file with your Department. These forms will be used with our Leading Edge policy form LTC-06 AR approved by your Department on 01/08/2007. The effective date for the use of these forms will be July 1, 2009 or immediately following approval if later. The purpose of this filing is as follows:

• Enhanced Elimination Period Endorsement – New Endorsement Form LTC-EEP 2/09 enhances the definition of Elimination Period by applying 7-days towards the satisfaction of the Elimination Period when 1-day of Home Health Care is received.

• CPI Compound Inflation Coverage & Guaranteed Increase Option Endorsement – Endorsement Form CORP-CPI/GIO 2/09 is identical to our previously approved Automatic Compound Inflation Coverage & Guaranteed Increase Option Endorsement Form LTC-CPI/GPO 6/07, approved by your Department on (date) 12/03/2007, except that we have changed the name of the Endorsement for marketing distribution purposes.

• 5% Compound Inflation Coverage - We would like to use previously approved Endorsement Form LTC-COMP with Leading Edge policy form LTC-06 AR. This endorsement provides 5% annual compound inflation coverage and was approved by your Department on 03/29/2002.

We are also submitting new applications and outlines of coverage in order to reflect the new filed features described above. Please see application forms: LTCAPP09-2 AR and CORPAPP09 -2 AR. Please see outline of coverage form OCLTC-07-2 AR 2/09.

In addition, we are enclosing a new Actuarial Memorandum to reflect these changes.

From time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/printed via website technology. Variable information is enclosed by brackets “[ ]” please see Appendix A for Statement of Variability.

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Company and Contact

Filing Contact Information

Richard Famiglietti, Sr. Contract Consultant
200 Berkeley Street
Boston, MA 02117

rfamiglietti@jhancock.com
(617) 572-1997 [Phone]
(617) 572-0399[FAX]

Filing Company Information

John Hancock Life Insurance Company
200 Berkeley Street

P O Box 111
Boston, MA 02117
(617) 572-5000 ext. [Phone]

CoCode: 65099
Group Code: 904

Group Name:
FEIN Number: 04-1414660

State of Domicile: Massachusetts
Company Type: Long Term Care Insurance

State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$200.00
Retaliatory?	Yes
Fee Explanation:	Forms = $50 per submission Rates = Retaliatory, MA requires $150 per filing
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
John Hancock Life Insurance Company	$200.00	02/24/2009	25920672

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Marie Bennett	03/12/2009	03/12/2009

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Actuarial Memorandum	Note To Reviewer	Richard Famiglietti	02/25/2009	02/25/2009

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Disposition

Disposition Date: 03/12/2009
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	Outline of Coverage		Yes
Supporting Document	Cover Letter		Yes
Supporting Document	NAIC Transmittal Form		Yes
Supporting Document	Health - Actuarial Justification		No
Form	Enhanced Elimination Period Endorsement		Yes
Form	CPI Compound Inflation Coverage & Guaranteed Increase Option		Yes
Form	Application		Yes
Form	Corporate Solutions Application		Yes
Form	Outline of Coverage		Yes

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Note To Reviewer

Created By:
Richard Famiglietti on 02/25/2009 02:59 PM
Last Edited By:
Marie Bennett
Submitted On:
03/12/2009 01:19 PM
Subject:
Actuarial Memorandum
Comments:
We discovered an error in the Actuarial Memorandum after the original submission, we have updated the document in the Supporting Documentation.

We apologize for any inconvenience this may have caused.

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Form Schedule

Lead Form Number: LTC-EEP 2/09

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	LTC-EEP 2/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	Enhanced Elimination Period Endorsement	Initial			LTC-EEP_2_09_final.pdf
	CORP-CPI/GIO 2/09	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	CPI Compound Inflation Coverage & Guaranteed Increase Option	Initial			CORP_CPI_GIO_209_final.pdf
	LTCAPP09 -2 AR	Application/Enrollment Form	Application	Initial			LTCAPP09-2_AR.pdf
	CORPAPP09 -2 AR	Application/Enrollment Form	Corporate Solutions Application	Initial			CORPAPP09-2_AR.pdf
	OCLTC-07-2 AR 2/09	Outline of Coverage	Outline of Coverage	Initial			OCLTC07-2_2_09_AR.pdf

John Hancock Life Insurance Company

Enhanced Elimination Period Endorsement

This Endorsement is made part of and should be attached to Your Policy. It is subject to all the provisions, conditions and limitations of the Policy unless otherwise provided below.

The definition of "Elimination Period" found in the DEFINITIONS section of Your Policy is deleted in its entirety and replaced with the following provision.

> **Elimination Period** (waiting period) means the number of Dates of Service that would otherwise be covered by this Policy, for which We will not pay benefits. The Elimination Period is shown in the Policy Schedule. Only one complete Elimination Period needs to be satisfied while Your Policy is in force.
>
> The Elimination Period starts on the first Date of Service. No Date of Service may be counted as more than one day towards the satisfaction of Your Elimination Period. The Dates of Service used to satisfy Your Elimination Period do not need to be consecutive and may be accumulated under separate claims. We will not pay benefits for charges during the Elimination Period, except for Hospice Care, Respite Care and the Additional Stay at Home Benefit. Days that You only receive Hospice Care, Respite Care or the Additional Stay at Home Benefit will not count toward the satisfaction of Your Elimination Period.
>
> If You receive Home Health Care for one or more days in a Calendar Week, We will apply seven days toward the satisfaction of Your Elimination Period, except if Respite Care is being received during the Calendar Week. If Respite Care is received during a Calendar Week, only the actual Dates of Service other than Respite Care will be applied toward satisfaction of Your Elimination Period. Please note that there will be no credit of days which occur before Your first Date of Service. (Calendar Week means the seven consecutive day period that begins on Sunday at 12:01 a.m.)

Termination

This Endorsement will terminate when the Policy terminates.

Signed for the Company at Boston, Massachusetts:

Secretary

JOHN HANCOCK LIFE INSURANCE COMPANY

ENDORSEMENT

CPI COMPOUND INFLATION COVERAGE AND GUARANTEED INCREASE OPTION

This Endorsement explains how Your Long-Term Care Benefit Amount increases to provide protection against the increasing cost of long-term care due to inflation.

This Endorsement is part of, and attached to Your Policy. It is subject to all the provisions of the Policy unless otherwise provided below.

Annual CPI Compound Increase in Long-Term Care Benefit Amount

We will increase the current Long-Term Care Benefit Amount on each Policy anniversary, while this Policy is in effect, beginning with the first Policy anniversary. The Long-Term Care Benefit Amount will be increased by the percentage change in the CPI three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long-Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long-Term Care Benefit Amount. When the Long-Term Care Benefit Amount is increased, the remaining Policy Limit (as well as other remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

CPI means the non-seasonally adjusted Consumer Price Index, Urban, All Items, published by the Bureau of Labor Statistics of the United States Department of Labor (CPI). If the CPI is discontinued, if there is a delay in the announcement of the CPI, or if its method of computation is changed, We may use another nationally published index. "CPI" will then mean the chosen index.

No inflation adjustment will be made while this Policy is in effect under the provisions of any nonforfeiture benefit.

The premium for this inflation coverage is included in Your Policy premium. Your premium will not change for any annual automatic CPI Compound increase, except as described in the Policy.

Guaranteed Increase Option

<u>Important Notice</u> – The Guaranteed Increase Option is *not* applicable to You if You are paying Your premium via the Ten-Year Premium Payment Option or the Paid-Up at Age 65 Payment Option.

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the Long-Term Care Benefit Amount that was in effect immediately prior to that Option Date. This increase is in addition to the annual automatic CPI Compound increase described above. No additional underwriting will be required.

At the time of each offer, We will provide You with information regarding: Your current Long-Term Care Benefit Amount; any increased benefit amount attributable to the CPI Compound increase due to take effect on that Option Date); the amount of increase available to You under this Guaranteed Increase Option; the additional premium amount for the increase under this Guaranteed Increase Option; and instructions on how You may elect this increase. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

If You elect an increase under the Guaranteed Increase Option, the amount of the annual automatic CPI Compound increase on that Option Date will be based on Your Long-Term Care Benefit Amount prior to this additional purchase.

If You <u>do not</u> elect an increase when offered, that increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers.

The premium for any increase under the Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect.

When the Long-Term Care Benefit Amount is increased under the Guaranteed Increase Option, the remaining Policy Limit (as well as any remaining Benefit Amounts listed in the Policy Schedule) will be increased by the same percentage as the increase in the Long-Term Care Benefit Amount and rounded to the nearest dollar.

The increase on any Option Date will not be available to You (and, if requested, will not take effect) if:

- any benefits have been payable under Your Policy during the two year period prior to the Option Date; or
- the Option Date occurs on or after Your 91st birthday.

No Guaranteed Increase Option offer or adjustment will be made while this Policy is in effect under any nonforfeiture benefit.

Termination

Nothing in this Endorsement will extend termination of the Policy or create a new Policy Limit after the then applicable Policy Limit is exhausted. This Endorsement will terminate when the Policy terminates, or when the Policy is continued under the provisions of any nonforfeiture benefit.

Signed for the Company at Boston, Massachusetts:

Secretary

For Home Office Use Only: Control Number A: Control Number B:

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

John Hancock Life Insurance Company, Boston, MA 02117

The applicant must initial any corrections made to this application.

NAME(S): Applicant A (First, M.I., Last)	Applicant B (First, M.I., Last)

PART I SHOULD YOU PROCEED WITH THIS APPLICATION?

		Applicant A		Applicant B	
1	Do you currently have, or have you ever had a diagnosis for: Alzheimer's Disease, Amyotrophic Lateral Sclerosis, Cystic Fibrosis, Dementia, Huntington's Chorea, Memory Loss, Mental Retardation, Multiple Myeloma, Multiple Sclerosis, Muscular Dystrophy, Myasthenia Gravis, Parkinson's Disease, Schizophrenia, Scleroderma, Spinal Cord Injury, Stroke/CVA	❑ Yes	❑ No	❑ Yes	❑ No
2	Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	❑ Yes	❑ No	❑ Yes	❑ No
3	Do you currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted care living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	❑ Yes	❑ No	❑ Yes	❑ No
4	Do you currently use one of the following medical devices: wheelchair; walker; crutches; hospital bed; quad cane; oxygen; stairlift; or dialysis?	❑ Yes	❑ No	❑ Yes	❑ No
5	Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	❑ Yes	❑ No	❑ Yes	❑ No

◆ Please do not continue with this application if you answered "Yes" to any of questions 1-5 above.

6	Are you covered by Medicaid (not Medicare)?	❑ Yes	❑ No	❑ Yes	❑ No

PART II ABOUT YOU

Applicant A (named above)			Applicant B (named above)		
Social Security #	Male ❑	Female ❑	Social Security #	Male ❑	Female ❑
Date of Birth (mm/dd/yyyy) Place of Birth (State, Country)			Date of Birth (mm/dd/yyyy) Place of Birth (State, Country)		
Street Address (no P.O. Box please)			Street Address ❑ Same as Applicant A		
City State Zip			City State Zip		
Tel. # Best time to call			Tel. # Best time to call		
Home: Work/Cell: ___ AM ___ PM			Home: Work/Cell: ___ AM ___ PM		
Email Address			Email Address		

PART III MEDICAL HISTORY

	Applicant A	Applicant B
1 Have you consulted with your Primary Care Physician within the last 18 months?	❑ Yes ❑ No	❑ Yes ❑ No

Applicant A: Primary Care Physician Name: _____

Address: _____

City, State, Zip Code: _____

Tel. #: _____

Date Last Seen: _____

Applicant B: Primary Care Physician Name: _____

Address: _____

City, State, Zip Code: _____

Tel. #: _____

Date Last Seen: _____

2 Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
3 What is your height?	►	►
4 What is your weight?	►	►
5 Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?		
a) **Circulatory Disorders:** Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms	❑ Yes ❑ No	❑ Yes ❑ No
b) **Endocrine and Pituitary Disorders:** Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease	❑ Yes ❑ No	❑ Yes ❑ No
c) **Cancers:** Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas	❑ Yes ❑ No	❑ Yes ❑ No
d) **Genitourinary Disorders:** Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders	❑ Yes ❑ No	❑ Yes ❑ No
e) **Gastrointestinal Disorders:** Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders, Cirrhosis	❑ Yes ❑ No	❑ Yes ❑ No
f) **Blood Disorders:** Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis	❑ Yes ❑ No	❑ Yes ❑ No
g) **Neurological Disorders:** Cerebral Atrophy, Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome, Memory Loss, Dementia, Alzheimer's Disease Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis	❑ Yes ❑ No	❑ Yes ❑ No
h) **Musculoskeletal Disorders:** Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Osteopenia, Polymyalgia Rheumatica, Paralysis, Crest	❑ Yes ❑ No	❑ Yes ❑ No
i) **Respiratory Disorders:** Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease	❑ Yes ❑ No	❑ Yes ❑ No
j) **Eye & Ear Disorders:** Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo	❑ Yes ❑ No	❑ Yes ❑ No
k) **Substance Abuse:** Alcoholism, Drug dependency, Illicit drug use	❑ Yes ❑ No	❑ Yes ❑ No
6 Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?	❑ Yes ❑ No	❑ Yes ❑ No
7 Within the last 5 years has any surgery or test(s) been recommended that has not been performed?	❑ Yes ❑ No	❑ Yes ❑ No
8 Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated?	❑ Yes ❑ No	❑ Yes ❑ No
9 Are you receiving any disability benefits?	❑ Yes ❑ No	❑ Yes ❑ No
If Yes, provide the disability %:	%	%

PLEASE NOTE: You may be contacted by a nurse on John Hancock's behalf to review your medical history and other information including height, weight, and blood pressure verification.

10 MEDICAL HISTORY DETAILS If you answered "Yes" to any of questions 5-9 in Part III above, please provide full details here (attach an additional signed and dated page if necessary).

Quest. #	Diagnosis, Disorder and/or Reason	Diagnosis Date	Treatment Dates	Name, Address, Tel. # of Physician, Provider and/or Insurer (if applicable), and Explanation or Comments
APPLICANT A				
APPLICANT B				

11 MEDICATIONS List all prescription medications taken at any time over the past 12 months.

Name of Medication	Dosage	Frequency	Reason Prescribed	Physician Name
APPLICANT A				
APPLICANT B				

PART IV COVERAGE SELECTION

		Applicant A	Applicant B
1	[Benefit Amount (choose either Daily or Monthly):	❑ Daily Benefit Amount	❑ Daily Benefit Amount
	$50 - $500 in $10 increments	$	$
	OR	❑ Monthly Benefit Amount	❑ Monthly Benefit Amount
	$1,500 - $15,000 in $100 increments	$	$
2	Benefit Period (Years):	❑ 3 ❑ 5 ❑ 5 Plus*	❑ 3 ❑ 5 ❑ 5 Plus*

* The 5 Plus option is a 5-year Benefit Period plus $1,000,000.

3 Inflation Option: Inflation protection coverage provides you with an important benefit. This policy provides inflation protection coverage. You may select the inflation protection coverage that best suits your needs from the choices below. By making your selection below, you are confirming that you have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with these inflation options. *(You must choose one of the options below)*

	Applicant A	Applicant B
▪ CPI Compound Inflation Coverage	❑	❑
▪ 5% Compound Inflation Coverage	❑	❑
▪ 5% Compound Guaranteed Purchase Inflation Coverage	❑	❑

4 Optional Riders:

	Applicant A	Applicant B
▪ SharedCare	❑	❑
▪ Enhanced Elimination Period	❑	❑
▪ Zero-Day Elimination Period for Home Care	❑	❑
▪ Nonforfeiture (if rejected, see also 4a below)	❑	❑

4a) Rejection of Nonforfeiture (if applicable): I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.

► You must check this box if you have NOT elected Nonforfeiture.	❑	❑]

[PART V DISCOUNTS

You may be eligible for discounts.

		Applicant A	Applicant B
	Marital/Partner Discount		
1	Are you married? OR	❑ Yes ❑ No	❑ Yes ❑ No
2	Are you in a committed relationship with a Partner or an immediate family member of the same generation, with whom you have been living for at least the past 3 years?	❑ Yes ❑ No	❑ Yes ❑ No
3	Is your Spouse, Partner or immediate family member of the same generation also applying for this insurance, or does he/she currently have an existing John Hancock individual long-term care insurance policy?	❑ Yes ❑ No If Yes, Policy # _____	❑ Yes ❑ No If Yes, Policy # _____
	Family Discount (Not available with the Sponsored Group Discount)		
4	Are you applying for a family discount? ►	❑ Yes ❑ No	❑ Yes ❑ No
	If Yes, please list two other family members applying for, or who currently have, a John Hancock individual long-term care insurance policy and their relationship to you:		
	Name 1:		
	Relationship		
	Policy #:		
	Name 2:		
	Relationship		
	Policy #:		
	Sponsored Group Discount		
5	Do you belong to a sponsored group? ►	❑ Yes ❑ No	❑ Yes ❑ No
	Please provide proof of employment/ membership with the sponsored group.		
	If Yes, Group #:		
	Group Name:		]

[PART VI CHOOSE YOUR PAYMENT METHOD

1 ALTERNATE PAYOR(S) IF DIFFERENT THAN APPLICANT(S)

Applicant A	Applicant B ❑ Same as Applicant A
Name (First, M.I., Last)	Name (First, M.I., Last)
Billing Address	Billing Address
City State Zip	City State Zip
Tel. #:	Tel. #:

2 CHOOSE ONE OF THE FOLLOWING PAYMENT METHODS FOR EACH APPLICANT		Applicant A	Applicant B
a) Direct Bill *	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
b) Monthly Bank Draft *	(Please check box ►)	❑	❑
Please include a voided check.	Select Draft Date (1-28):		
	Bank Account #:		
❑ Check here if bank draft information is the same for both Applicants A and B.	Account Type:	❑ Checking ❑ Savings	❑ Checking ❑ Savings
The first draft will occur on the premium due date after the policy has been issued. Subsequent drafts will occur on the selected draft date requested above.	Bank Name:		
	Bank Routing Number:		
	Name(s) of Depositor(s)		
* An advance check payment is required for Direct Bill / Monthly Bank Draft. I have enclosed my advance payment in the amount of:		$	$
Please make your check payable to 'John Hancock Life Insurance Company'.		(A minimum of one month of the quoted premium)	
c) Credit/Debit Card	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
	Monthly	❑	❑
❑ Check here if the card information is the same for both Applicants A and B.	Card Type:	❑ Visa ❑ Mastercard	❑ Visa ❑ Mastercard
	Card Number:		
	Expiration Date:		
	Cardholder's Name:		
d) List Bill	(Please check box ►)	❑	❑
	Group Number:		
	Group Name:		
3 LIMITED PAYMENT OPTION (neither is available with the 5% Compound Guaranteed Purchase Inflation Coverage).	10-Year Limited Payment Option, OR	❑	❑
	Paid-Up at Age 65 Limited Payment Option	❑	❑]

PART VII DESCRIBE YOUR INSURANCE HISTORY

	Applicant A	Applicant B
1 Have you had another long-term care insurance policy or certificate in force during the last 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, insurance company:		
If now lapsed, date of lapse:		
2 Do you have another long-term care insurance policy or certificate in force (including a health care service, health maintenance, or Medicare supplement contract)?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, insurance company:		
Policy/Cert. #:		
Annual premium:		
Daily benefit:	$	$
Benefit type & amounts:		
3 Do you intend to replace any of your long-term care, medical or health insurance coverage with the policy for which you are applying?	❑ Yes ❑ No	❑ Yes ❑ No
If yes, insurance company:		

PART VIII SPECIAL REQUESTS:

PART IX PROTECTION AGAINST UNINTENDED LAPSE (Check one box below for each applicant.)

I understand that I have the right to name another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A	Applicant B
❑ I elect NOT to designate any person to receive such notice, or ❑ I elect to designate the person below to receive such notice.	❑ I elect NOT to designate any person to receive such notice, or ❑ I elect to designate the person below to receive such notice.
Name of Person (First, M.I., Last)	Name of Person (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip

PART X MAKE DECLARATIONS AND PROVIDE AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT

I understand and agree as follows:

a. I have received the Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure Form, the Shopper's Guide to Long term Care Insurance and a Replacement Notice (if replacing coverage), and the "Guide to Health Insurance for People with Medicare" (if eligible for Medicare).

b. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.

c. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.

d. John Hancock Life Insurance Company ("John Hancock") may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.

e. My statements and answers on this application are true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

[f. I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of a policy that contains 5% compound inflation protection. By applying for this policy, I understand that I am rejecting a policy that contains 5% compound inflation protection.]

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

PREMIUM AGREEMENT AND AUTHORIZATION

I understand and agree that:

a. Completing this application or making an advance payment is not a guarantee that my application will be approved. If approved, the effective date will be indicated in the policy issued.

b. If my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.

c. If making an advance payment, my check(s) will be held in a non-interest bearing account while John Hancock reviews this application for acceptance.

d. By making an advance payment by check or by providing a credit card authorization with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. And, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen.
[*The following provision is applicable to payroll deduction, list-billed or employer-paid plans where no advance payment is required:* I understand that my health status will not be frozen when no advance payment is made. I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.)]

e. If bank draft is the selected method of payment, the first draft will occur on the premium due date after my policy has been issued. Subsequent drafts will occur on the selected draft day requested in Part VI of this application.

f. In order to keep my policy in force, I must pay all the required premiums when due. The premiums deducted or charged will be as shown on the policy or the most recent premium change notice issued to the policyholder by John Hancock.

g. I authorize John Hancock to deduct from my bank or charge my credit/debit card all required premiums, based upon my selected method of payment as shown in Part VI, indefinitely until I provide written notice of cancellation to John Hancock at the servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

Fraud Notice. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

Applicant(s): I have reviewed this application including all elections and answers contained within.
By my signature, I affirm all my elections and answers in this application.

X	X
Signature of Applicant A	Signature of Applicant B
Signed At: (City & State) / Date	Signed At: (City & State) / Date

[PART XI PRODUCER/AGENT'S STATEMENT

	Applicant A	Applicant B
► Please indicate the Underwriting Risk classification quoted: Note: Underwriting will determine the appropriate risk class, regardless of that quoted to the applicant. We will communicate any change to you.	❑ Preferred ❑ Select	❑ Preferred ❑ Select
Replacement: To the best of my knowledge, replacement of other insurance (check box) involved in this transaction.	❑ is / ❑ is not	❑ is / ❑ is not

Listed below are all other health insurance policies I have (i) sold to the Applicant which are still in force; and (ii) sold to the Applicant in the last five years which are no longer in force.

Applicant A/B	Company	Type of Policy	Effective Date	In Force?
				❑ Yes ❑ No
				❑ Yes ❑ No
				❑ Yes ❑ No

Signature of Licensed Agent: _____

Agent Name (Please print): _____ Date: _____

Please attach the illustration presented to the Applicant(s).]

[PART XII CREDIT FOR APPLICATION

Please complete as much as possible to facilitate correct credit.

Agency/Bank/Firm Name: _____

Secondary Firm Name (if applicable): _____

Producer/Agent Name (Please print): _____

Producer SS#: _____

Tel. #: _____

Fax Number: _____

Email: _____

To be completed by JHFN producers only:

Agency Code (if known): _____

Payroll Number: _____

Contract Code: _____

If more than one producer was involved in this sale, provide details here:

Producer Name: _____ Percentage: _____

Producer SS#: _____

Agency/Firm: _____

Producer Name: _____ Percentage: _____

Producer SS#: _____

Agency/Firm: _____

Producer Name: _____ Percentage: _____]

Producer SS#: _____

Agency/Firm: _____

For Home Office Use:	Control No. A	Control No. B

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE

John Hancock Life Insurance Company, Boston, MA 02117
[Corporate Solutions]

NAME(S): Applicant A (First, M.I., Last):	Applicant B (First, M.I., Last):

PART 1 BUSINESS INFORMATION

Sponsoring Employer Name:		
Street Address of Employer:		
City:	**State:**	**Zip Code:**

[For Agent Use Only:

Applicant A	Applicant B
Underwriting Program:	**Underwriting Program:**
❑ Simplified ❑ Full	❑ Simplified ❑ Full
Employer Group *or* Sponsored Group #:	**Employer Group *or* Sponsored Group #:**
Benefit Tier:	**Benefit Tier:**
❑ Tier I ❑ Tier II ❑ Tier III	❑ Tier I ❑ Tier II ❑ Tier III]

APPLICATION FOR INDIVIDUAL LONG-TERM CARE INSURANCE
John Hancock Life Insurance Company, Boston, MA 02117

The applicant(s) must initial any corrections made to the application

PART 2 ABOUT YOU

Applicant A	Applicant B
Social Security #: Male ❑ Female ❑	Social Security #: Male ❑ Female ❑
Date of Birth (mm/dd/yyyy): Place of Birth (State, Country):	Date of Birth (mm/dd/yyyy): Place of Birth (State, Country):
What is your height and weight?	What is your height and weight?
Height: Weight:	Height: Weight:
Street Address (no P. O. Box please)	Street Address (no P. O. Box please)
City State Zip	City State Zip
Tel. # : Best time to call:	Tel. # : Best time to call:
Home: Work/Cell: ___ AM ___ PM	Home: Work/Cell: ___ AM ___PM
Email Address:	Email Address:
Are you currently actively at work? ❑ Yes ❑ No	Are you currently actively at work? ❑ Yes ❑ No

[You are "actively at work" if you meet the benefit eligibility requirements for receiving full time employee benefits as determined by your employer, with a minimum of no less than 30 hours per week and you are at work on the effective date of the policy.]

[Relationship to Employee:	Relationship to Employee:
Which applies to you?	Which applies to you?
❑ Active Employee ❑ Newly Hired Employee ❑ Newly Eligible Employee ❑ Employee Returning from Leave ❑ Other	❑ Active Employee ❑ Newly Hired Employee ❑ Newly Eligible Employee ❑ Employee Returning from Leave ❑Other *or* **Spouse/Partner of:** ❑ Active Employee ❑ Newly Hired Employee ❑ Newly Eligible Employee ❑ Employee Returning from Leave]
Active Employee's Date of Hire./ Eligibility (mm/dd/yyyy)	Active Employee's Date of Hire./ Eligibility (mm/dd/yyyy)

PART 3 INSURABILITY QUESTIONS

[SIMPLIFIED UNDERWRITING PROGRAM – If you are part of the Simplified Underwriting Program please complete Section A and skip to Part 4. If you are part of the full underwriting program please complete all Parts of the application.

Section A

- **Please check "yes" or "no" to each question. If "yes", circle all diagnoses or conditions that apply.**
- **If you answer "yes" to any question 1-6, then we suggest you do not submit an application. We will be unable to offer you coverage.]**

	Applicant A	Applicant B
1 Do you have or have you ever been diagnosed for: • Alzheimer's Disease • Amyotrophic Lateral Sclerosis (ALS) • Cirrhosis • Chronic Kidney Failure • Dementia • Diabetes –treated with greater than 49 units of insulin or with amputation or ongoing complications affecting the kidney • Memory Loss • Mental Retardation • Metastatic Cancer • Multiple Sclerosis • Muscular Dystrophy • Neurological Conditions affecting the Brain or Spinal Cord • Organic Brain Syndrome • Parkinson's Disease • Paralysis • Post Polio Paralytic Syndrome • Schizophrenia • Scleroderma • Systemic Lupus Erythematosus • Stroke/CVA • TIA's 2 or more	❑ Yes ❑ No	❑ Yes ❑ No
2 Do you currently require human assistance or supervision in any of the following activities: eating; dressing; toileting; transferring from bed to chair; walking; maintaining continence; or bathing?	❑ Yes ❑ No	❑ Yes ❑ No
3 Do currently reside in, have you been advised to enter, or are you planning to enter a nursing home, assisted living facility or other custodial facility, or are you currently receiving home health care services or attending adult day care?	❑ Yes ❑ No	❑ Yes ❑ No
4 Do you currently use one of the following medical devices: wheelchair; walker; crutches; hospital bed; quad cane; oxygen; stairlift; or dialysis?	❑ Yes ❑ No	❑ Yes ❑ No
5 Have you been diagnosed or treated by a member of the medical profession for AIDS (Acquired Immune Deficiency Syndrome) or AIDS Related Complex?	❑ Yes ❑ No	❑ Yes ❑ No
6 Are you currently receiving Social Security Disability, Worker's Compensation or Long -Term Disability Benefits?	❑ Yes ❑ No	❑ Yes ❑ No

[Section B

If you are part of the Simplified Underwriting Program please skip to Part 4.

MEDICAL HISTORY	Applicant A	Applicant B
1 Have you consulted with your Primary Care Physician within the last 18 months?	❑ Yes ❑ No	❑Yes ❑ No

Applicant A: Primary Care Physician Name:	**Applicant B:** Primary Care Physician Name:
_____	_____
Address:_____	Address:_____
City, State, Zip Code:_____	City, State, Zip Code:_____
Tel. #: _____	Tel. #: _____
Date Last Seen: _____	Date Last Seen: _____

MEDICAL HISTORY (cont.)	Applicant A		Applicant B	
2 Have you used tobacco products (cigarettes, pipe, cigar, or chewing tobacco) in the last 12 months?	❑ Yes	❑ No	❑ Yes	❑ No
3 Within the last 10 years, have you received medical advice, diagnosis or treatment, or consulted with a member of the medical profession for any of the following conditions?				
a) Circulatory Disorders: Transient Ischemic Attack, Amaurosis Fugax, Heart Arrhythmias, Valvular Disease, Cardiomyopathy, Congestive Heart Failure, Aneurysm, Coronary Artery Disease, High Blood Pressure, Peripheral Vascular Disease, Carotid Artery Disease, Embolisms	❑ Yes	❑ No	❑ Yes	❑ No
b) Endocrine and Pituitary Disorders: Diabetes, Addison's Disease, Pancreatitis, Cushing's Disease	❑ Yes	❑ No	❑ Yes	❑ No
c) Cancers: Leukemia, Lymphoma, Tumors, Melanoma, Squamous Cell, Sarcomas	❑ Yes	❑ No	❑ Yes	❑ No
d) Genitourinary Disorders: Renal Insufficiency, Kidney Failure, Incontinence, Prostate Disorders, Bladder Disorders	❑ Yes	❑ No	❑ Yes	❑ No
e) Gastrointestinal Disorders: Hepatitis, Ulcerative Colitis, Crohn's Disease, Liver Disorders	❑ Yes	❑ No	❑ Yes	❑ No
f) Blood Disorders: Anemia, Polycythemia Vera, Thrombocytopenia, Hemochromatosis	❑ Yes	❑ No	❑ Yes	❑ No
g) Neurological Disorders: Cerebral Atrophy, Mental Illness, Depression, Seizures, Tremors, Neuropathy, Syncope, Anxiety, Chronic Fatigue Syndrome, Memory Loss, Dementia, Alzheimer's Disease, Amyotrophic Lateral Sclerosis (ALS) or Multiple Sclerosis	❑ Yes	❑ No	❑ Yes	❑ No
h) Musculoskeletal Disorders: Osteoporosis, Arthritis, Rheumatoid Arthritis, Osteoarthritis, Fractures, Fibromyalgia, Degenerative Joint Disease, Scoliosis, Spinal Stenosis, Lupus, Osteopenia, Polymyalgia Rheumatica, Paralysis, Crest	❑ Yes	❑ No	❑ Yes	❑ No
i) Respiratory Disorders: Emphysema, Bronchitis, Asthma, Bronchiectasis, Asbestosis, Sarcoidosis, Chronic Obstructive Pulmonary Disease	❑ Yes	❑ No	❑ Yes	❑ No
j) Eye & Ear Disorders: Macular Degeneration, Glaucoma, Retinitis Pigmentosa, Labrynthitis, Meniere's/Vertigo	❑ Yes	❑ No	❑ Yes	❑ No
k) Substance Abuse: Alcoholism, Drug dependency, Illicit drug use	❑ Yes	❑ No	❑ Yes	❑ No
4 Within the last 10 years have you been hospitalized or have you consulted or been treated by a member of the medical profession for any reason not previously stated?	❑ Yes	❑ No	❑ Yes	❑ No
5 Within the last 5 years has any surgery or test(s) been recommended that has not been performed?	❑ Yes	❑ No	❑ Yes	❑ No
6 Have you ever had an application for life, accident, medical or health, disability or long-term care insurance declined, postponed, modified or rated?	❑ Yes	❑ No	❑ Yes	❑ No
7 Are you receiving any disability benefits?	❑ Yes	❑ No	❑ Yes	❑ No
If Yes, provide the disability %:		%		%

PLEASE NOTE: You may be contacted by a nurse on John Hancock's behalf to review your medical history and other information including height, weight, and blood pressure verification.

8 MEDICAL HISTORY DETAILS

If you answered "Yes" to any of questions 3-7 in Section B above, please provide full details here. (Attach an additional signed and dated page if necessary).

Quest. #:	Diagnosis, Disorder and/or Reason:	Diagnosis Date:	Treatment Dates:	Name, Address, Tel. # of Physician, Provider and/or Insurer (if applicable), and Explanation or Comments:
APPLICANT A				
APPLICANT B				

9 MEDICATIONS

List all prescription medications taken at any time over the past 12 months.

Name of Medication:	Dosage:	Frequency:	Reason Prescribed:	Physician Name:
APPLICANT A				
APPLICANT B				
				]

PART 4 COVERAGE SELECTION

[Simplified Underwriting Program – Maximum benefit limits - Daily Benefit Amount $300; Monthly Benefit Amount $9000 and Benefit Period up to 5 Years.

		Applicant A	Applicant B
1	**Benefit Amount** (choose either Daily or Monthly):	❑ **Daily Benefit Amount**	❑ **Daily Benefit Amount**
	$50 - $500 in $10 increments	$	$
	OR	❑ **Monthly Benefit Amount**	❑ **Monthly Benefit Amount**
	$1,500 - $15,000 in $100 increments	$	$
2	**Benefit Period (Years):**	❑ **3 Years**	❑ **3 Years**
		❑ **5 Years**	❑ **5 Years**
		❑ **5 Years Plus***	❑ **5 Years Plus***
	***The 5 Plus option is a 5-year Benefit Period plus $1,000,000. This option is not available if you are part of the Simplified Underwriting Program.**		
3	**Inflation Option:** Inflation protection coverage provides you with an important benefit. This policy provides inflation protection coverage. You may select the inflation protection coverage that best suits your needs from the choices below. By making your selection below, you are confirming that you have reviewed the outline of coverage and the graphs that compare the benefits and premiums of this policy with these inflation options. *(You must choose one of the options below)*		
	▪ CPI Compound Inflation Coverage	❑	❑
	▪ 5% Compound Inflation Coverage	❑	❑
	▪ 5% Compound Guaranteed Purchase Inflation Coverage	❑	❑
4	**Optional Riders:**		
	▪ SharedCare	❑	❑
	▪ Enhanced Elimination Period	❑	❑
	▪ Zero-Day Elimination Period for Home Care	❑	❑
	▪ Nonforfeiture (if rejected, see 4a below)	❑	❑
4a	**Rejection of Nonforfeiture** (if applicable): I have reviewed the Outline of Coverage and the Nonforfeiture benefit described therein. Specifically, I have reviewed this optional benefit available to me and I reject the Nonforfeiture benefit.		
►	You **must** check this box if you have **NOT** elected Nonforfeiture.	❑	❑

PART 5 DISCOUNTS

You may be eligible for discounts.	Applicant A	Applicant B
Are you married? **OR**	❑ Yes ❑ No	❑ Yes ❑ No
Are you in a committed relationship with a Partner or an immediate family member of the same generation, with whom you have been living for at least the past 3 years?	❑ Yes ❑ No	❑ Yes ❑ No
Is your Spouse, Partner or immediate family member of the same generation also applying for this insurance, or does he/she currently have an existing John Hancock individual long-term care insurance policy?	❑ Yes ❑ No If Yes, Policy #; Name; or SS # _____ _____	❑ Yes ❑ No If Yes, Policy #; Name; or SS # _____ _____]

[PART 6 CHOOSE YOUR PAYMENT METHOD

1	WHO WILL BE PAYING THE PREMIUM?	
	Applicant A	**Applicant B** ❑ Same as Applicant A
	❑ Employer Paid ❑ Insured Paid ❑ Combination	❑ Employer Paid ❑ Insured Paid ❑ Combination

2 CHOOSE ONE OF THE FOLLOWING PAYMENT METHODS FOR EACH APPLICANT		**Applicant A**	**Applicant B**
a) List Bill	(Please check box ►)	❑	❑
	List Bill Number:		
b) Monthly Bank Draft *	(Please check box ►)	❑	❑
Please include a voided check.	Select Draft Date (1-28):		
	Bank Account #:		
❑ Check here if bank draft information is the same for both Applicants A and B.	Account Type:	❑ Checking ❑ Savings	❑ Checking ❑ Savings
The first draft will occur on the premium due date after the policy has been issued. Subsequent drafts will occur on the selected draft date requested above.	Bank Name:		
	Bank Routing Number:		
	Name(s) of Depositor(s)		
c) Direct Bill *	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
*** An advance check payment is required for Direct Bill/Monthly Bank Draft.** I have enclosed my advance payment in the amount of:		**$**	**$**
Please make your check payable to 'John Hancock Life Insurance Company'.		(A minimum of one month of the quoted premium)	
d) Credit/Debit Card	(Please check box ►)	❑	❑
Select how often you would like to be billed:	Annual	❑	❑
	Semi-Annual	❑	❑
	Quarterly	❑	❑
	Monthly	❑	❑
❑ Check here if the card information is the same for both Applicants A and B.	Card Type:	❑ Visa ❑ Mastercard	❑ Visa ❑ Mastercard
	Card Number:		
	Expiration Date:		
	Cardholder's Name:		

3 LIMITED PAYMENT OPTION (neither is available with the 5% Compound Guaranteed Purchase Inflation Coverage)			
	10-Year Limited Payment Option, **OR**	❑	❑
	Paid-Up at Age 65 Limited Payment Option	❑	❑]

PART 7 DESCRIBE YOUR INSURANCE HISTORY

		Applicant A		Applicant B	
1 Have you had another long-term care insurance policy or certificate in force during the last 12 months?		❑ Yes	❑ No	❑ Yes	❑ No
	If yes, insurance company:				
	If now lapsed, date of lapse:				
2 Do you have another long-term care insurance policy or certificate in force (including a health care service, health maintenance, or Medicare supplement contract)?		❑ Yes	❑ No	❑ Yes	❑ No
	If yes, insurance company:				
	Policy/Cert. #:				
	Annual premium:				
	Daily benefit:	$		$	
	Benefit type & amounts:				
3 Do you intend to replace any of your long -term care, medical or health insurance coverage with the policy for which you are applying?		❑ Yes	❑ No	❑ Yes	❑ No
	If yes, insurance company:				
4 Are you covered by Medicaid (not Medicare)?		❑ Yes	❑ No	❑ Yes	❑ No

PART 8 SPECIAL REQUESTS

PART 9 PROTECTION AGAINST UNINTENDED LAPSE

(Check one box below for each applicant.)

I understand that I have the right to name another person to receive Notice of Lapse/Termination of my insurance policy for non-payment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Applicant A	Applicant B
❑ I elect NOT to designate any person to receive such notice, or	❑ I elect NOT to designate any person to receive such notice, or
❑ I elect to designate the person below to receive such notice.	❑ I elect to designate the person below to receive such notice.
Name of Person (First, M.I., Last)	Name of Person (First, M.I., Last)
Address:	Address:
City State Zip	City State Zip

PART 10 MAKE DECLARATIONS AND PROVIDE AUTHORIZATIONS

GENERAL AGREEMENT & ACKNOWLEDGMENT - I understand and agree as follows:

a. I have received the Outline of Coverage, the Notice of Insurance Information Practices, Suitability forms, the Potential Rate Increase Disclosure Form, the Shopper's Guide to Long-term Care Insurance and a Replacement Notice (if replacing coverage), and the "Guide to Health Insurance for People with Medicare" (if eligible for Medicare).
b. In order for the underwriting of this application to proceed, this application and all underwriting requirements must be complete.
c. No agent or medical examiner has the authority from John Hancock to accept any risk, determine insurability, or waive or change any requirements or questions on this application.
d. John Hancock Life Insurance Company ("John Hancock") may require an attending physician's statement, medical records, an underwriting assessment, a medical examination, motor vehicle report or other questionnaire or test.
e. My statements and answers on this application are true, complete and correctly recorded. They are representations and not warranties, and will be part of and form the basis of my policy.

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE INCORRECT OR UNTRUE, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE.

PREMIUM AGREEMENT AND AUTHORIZATION - I understand and agree that:

a. Completing this application or making an advance payment is not a guarantee that my application will be approved. If approved, the effective date will be indicated in the policy issued.
b. If my application is declined, the long-term care insurance coverage applied for will not become effective and any advance payment submitted with the application will be refunded to me, without interest.
c. If making an advance payment, my check(s) will be held in a non-interest bearing account while John Hancock reviews this application for acceptance.
d. By making an advance payment by check or by providing a credit card authorization with this application, my health status will be frozen as of the later of: the date I sign this application or the date I complete all physical exams or tests required by John Hancock, if applicable. This means that any change in my health that occurs after the date my health status is frozen will not affect the underwriting of my application. And, if my application is approved, my eligibility for benefits may begin on the date my health status was frozen.
[*The following provision is applicable to payroll deduction, list-billed or employer-paid plans where no advance payment is required:* I understand that my health status will not be frozen when no advance payment is made. I agree to notify John Hancock in writing if, before the policy's effective date, I have a change in health, or if any answer I gave in the application is no longer correct. If I fail to do so and a policy is issued to me, I understand that John Hancock may deny benefits or rescind my coverage. I understand that the policy will take effect only if: John Hancock has approved this application and the first premium has been paid. If my application is approved, the effective date of my policy will be stated in the policy issued to me. (I understand that I may request a later effective date and, if such request is approved, my coverage will be delayed until such later effective date.)]
e. If bank draft is the selected method of payment, the first draft will occur on the premium due date after my policy has been issued. Subsequent drafts will occur on the selected draft day requested in Part 6 of this application.
f. In order to keep my policy in force, I must pay all the required premiums when due. The premiums deducted or charged will be as shown on the policy or the most recent premium change notice issued to the policyholder by John Hancock.
g. I authorize John Hancock to deduct from my bank or charge my credit/debit card all required premiums, based upon my selected method of payment as shown in Part VI, indefinitely until I provide written notice of cancellation to John Hancock at the servicing address stated in the policy, after allowing a reasonable time to act upon my notification. I agree to contact John Hancock if there are any changes to my account information. John Hancock reserves the right to terminate this payment plan at any time.

Fraud Notice. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement.

Applicant(s): I have reviewed this application including all elections and answers contained within. By my signature, I affirm all my elections and answers in this application.

X	**X**
Signature of Applicant A	Signature of Applicant B
Signed At: (City & State) Date	Signed At: (City & State) Date

[PART 11 PRODUCER/AGENT'S STATEMENT

	Applicant A	Applicant B
► **Please indicate the Underwriting Risk classification quoted:**	❑ **Preferred** ❑ **Select**	❑ **Preferred** ❑ **Select**
Note: Underwriting will determine the appropriate risk class, regardless of that quoted to the applicant. We will communicate any change to you.		
Replacement:		
To the best of my knowledge, replacement of other insurance (check box) involved in this transaction.	❑ is / ❑ is not	❑ is / ❑ is not

Listed below are all other health insurance policies I have (i) sold to the Applicant which are still in force; and (ii) sold to the Applicant in the last five years which are no longer in force.

Applicant A/B	Company	Type of Policy	Effective Date	In Force?	
				❑ Yes	❑ No
				❑ Yes	❑ No
				❑ Yes	❑ No

Signature of Licensed Agent:			
Agent Name (Please print):		Date:	

Please attach the illustration presented to the Applicant(s).]

PART 12 CREDIT FOR APPLICATION

Please complete as much as possible to facilitate correct credit.

Agency/Bank/Firm Name:			
Secondary Firm Name (if applicable):			
Producer/Agent Name (Please print):			
Producer SS#:		**To be completed by JHFN producers only:**	
Tel. #:		Agency Code (if known):	
Fax Number:		Payroll Number:	
Email:		Contract Code:	

If more than one producer was involved in this sale, provide details here:

Producer Name:		Percentage:	
Producer SS#:			
Agency/Firm:			
Producer Name:		Percentage:	]
Producer SS#:			
Agency/Firm:			

Outline of Coverage

Long-Term Care Insurance
Policy Series LTC-06 AR

John Hancock Life Insurance Company
[LTC Administrative Office
333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203]

CAUTION: The issuance of this long-term care insurance Policy is based upon Your responses to the questions on Your application. A copy of Your application is enclosed. If Your answers are incorrect or untrue, the company has the right to deny benefits or rescind Your Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact the company at this address: John Hancock Life Insurance Company, [LTC Administrative Office, 333 West Everett Street, P.O. Box 2986, Milwaukee, WI 53203 or call Us at 1-800-377-7311.]

NOTICE TO BUYER: This Policy may not cover all of the costs associated with long-term care incurred by You during the period of coverage. You are advised to review carefully all Policy limitations.

1. This Policy is an individual policy of insurance.

2. PURPOSE OF OUTLINE OF COVERAGE. This Outline of Coverage provides a very brief description of the important features of this Policy. You should compare this Outline of Coverage to outlines of coverage for other policies available to You. This is not an insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail the rights and obligations of both You and the insurance company. Therefore, if You purchase this coverage, or any other coverage, it is important that You READ YOUR POLICY CAREFULLY!

3. FEDERAL TAX CONSEQUENCES. This Policy is intended to be a qualified long-term care contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

   Long-term care insurance was granted favorable federal income tax treatment in the Health Insurance Portability and Accountability Act of 1996. Policies meeting certain criteria outlined in this Act are eligible for this treatment. To the best of Our knowledge, We have designed this Policy to meet the requirements of this law. If, in the future, it is determined that this Policy does not meet these requirements, We will make every reasonable effort to amend the Policy if We are required to do so in order to gain such favorable federal income tax treatment. We will offer you an opportunity to receive these amendments.

4. TERMS UNDER WHICH THE POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

   (a) RENEWABILITY: THIS POLICY IS GUARANTEED RENEWABLE. This means You have the right, subject to the terms of Your Policy to continue this Policy as long as You pay Your premiums on time. John Hancock cannot change any of the terms of Your Policy on its own, except that, in the future, IT MAY INCREASE THE PREMIUM YOU PAY.

   (b) WAIVER OF PREMIUM. We will waive the payment of premiums under this Policy if You are receiving services for which benefits are payable under the Long-Term Care Benefit. The waiver period will start the day after You have satisfied 100 Dates of Service and will end on the date when benefits are no longer payable. The premium will not be waived, however, if benefits are only being received under the Additional Stay at Home Benefit.

5. TERMS UNDER WHICH THE COMPANY MAY CHANGE PREMIUMS. We reserve the right to increase Your premium as of any premium due date; however, any changes in premium rates must apply to all similar policies issued in Your state on this Policy form. This means We cannot single You out for an increase because of any change in Your age or health. However, Your rates may go up based on the experience of all policyholders with a policy similar to Yours.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUMS REFUNDED

   (a) THIRTY DAY FREE LOOK. If You are not completely satisfied with this Policy for any reason, You may return it within 30 days from the date it was delivered to You. We will then refund any premium paid, and the Policy will be treated as if it had never been issued.

   (b) REFUND OF UNEARNED PREMIUMS. Upon receipt of notice that You have died, We will refund the premium paid for any period beyond the date of death.

7. THIS IS NOT A MEDICARE SUPPLEMENT POLICY

If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from John Hancock. Neither John Hancock Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

8. LONG-TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventative, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the home.

This Policy provides coverage for actual charges incurred for care up to the applicable Benefit Amount for covered long-term care expenses, subject to Policy limitations and requirements.

9. BENEFITS PROVIDED BY THIS POLICY

Benefit Limits Selected:		Applicant A		Applicant B
• [Long-Term Care Benefit Amount • Monthly Benefit $1,500 to $15,000 in $100 increments • *Daily Benefit* $50 to $500 in $10 increments		$_____		$_____
• Benefit Period 3-year, 5-year or 5-year Plus* * The 5 Plus option is a 5-year Benefit Period plus $1,000,000		_____		_____
• Elimination Period		100 Dates of Service		100 Dates of Service
• Inflation Protection				
• CPI Compound Inflation Coverage		☐		☐
• 5% Compound Inflation Coverage		☐		☐
• 5% Compound Guaranteed Purchase Inflation Coverage		☐		☐
• Optional Benefits Selected				
• SharedCare		☐		☐
• Enhanced Elimination Period		☐		☐
• Zero-Day Elimination Period for Home Health Care & Adult Day Care		☐		☐
• Nonforfeiture		☐		☐]

Important Note: You may choose either a monthly or daily Long-Term Care Benefit Amount. This choice is important as other Policy benefits are dependent upon this choice. We will provide You with information on how a choice of a monthly or daily Long-Term Care Benefit Amount will impact Policy benefits.

(a) Long-Term Care Benefit. Subject to Policy requirements and limitations, this Policy provides coverage for actual charges up to the Long-Term Care Benefit Amount incurred by:

- Your confinement in a Nursing Home or Assisted Living Facility for Your room, board and care services (such care services being Nursing Care, Custodial Care and Hospice Care);
- Home Health Care (including homemaker services), Hospice Care, Respite Care; or
- attendance at an Adult Day Care Center providing Adult Day Care.

Please note the following:

- The Elimination Period shall not apply to Hospice Care. During Your Elimination Period, actual charges incurred for Hospice Care up to the Long-Term Care Benefit Amount are payable under the terms of this Policy.

- The Elimination Period shall not apply to Respite Care. During Your Elimination Period, actual charges incurred for Respite Care are payable up to the Respite Care Benefit Amount per day for up to 21-days in any Policy Year subject to the terms of this Policy. The Respite Care Benefit Amount is equal to 1/30th of the Long-Term Care Benefit Amount if the monthly option is chosen, or the Long-Term Care Benefit Amount if the daily option is chosen. Please note that after Your Elimination Period has been satisfied, We will pay the actual charges incurred for Respite Care up to the Long-Term Care Benefit Amount.
- If Your stay in a Nursing Home or Assisted Living Facility is interrupted for any reason and a benefit is payable under this Policy, We will continue to pay the actual charges for up to 60-days in any calendar year in order to reserve Your bed during Your absence.

We will not pay benefits for charges during the Elimination Period, except for Hospice Care, Respite Care and the Additional Stay at Home Benefit. Elimination Period (waiting period) means the number of Dates of Service that would otherwise be covered by this Policy, for which We will not pay benefits. Only one complete Elimination Period needs to be satisfied while Your Policy is in force. The Elimination Period starts on the first Date of Service. No Date of Service may be counted as more than one day towards the satisfaction of Your Elimination Period. The Dates of Service used to satisfy Your Elimination Period do not need to be consecutive and may be accumulated under separate claims. Days that You only receive Hospice Care, Respite Care or the Additional Stay at Home Benefit will not count toward the satisfaction of Your Elimination Period.

(b) Care Coordination: Care Coordination provides You with an important and valuable resource. The Care Coordination Benefit provides You and Your family members with access to the services of a Care Coordinator who is also a Licensed Health Care Practitioner. The Care Coordinator will assess Your needs for long-term care, develop a written Plan of Care designed to meet those needs, and help You and Your family to navigate through the long-term care delivery system; and may assist in the coordination and the monitoring of long-term care services as appropriate. In addition, using the Care Coordination Benefit will help You minimize the paperwork by streamlining the claim process.

The entire cost of the services provided by the Care Coordinator is paid by Us and will ***not*** count against Your Policy Limit. In addition, the Elimination Period does ***not*** have to be met in order for You to receive Care Coordination services. *Please note that use of the Care Coordination is entirely voluntary.*

When You choose to access the Care Coordination Benefit, the Care Coordinator may provide You with the following services:

- *Assessment and Certification*. The Care Coordinator will conduct an assessment to determine Your status and needs. The assessment encompasses a wide range of factors that make Your situation unique, such as Your functional, cognitive, behavioral, and emotional well-being, as well as family support and the safety of Your environment. This assessment of Your needs will form the basis of the Care Coordinator's Certification that You are a Chronically Ill Individual and Your Plan of Care.
- *Development of Your Plan of Care.* The Care Coordinator will work with You, Your Physician, Your family or Your representative, to develop a Plan of Care. This is a collaborative process. The Plan of Care will describe the type and frequency of services that will meet Your needs as identified in the assessment.
- *Coordinating Service Delivery.* The Care Coordinator may assist You in securing the services recommended in Your Plan of Care as necessary. The Care Coordinator will provide You with information on provider resources local to You, community programs, and health information resources.
- *Monitoring.* After You begin to receive services through Your Plan of Care, We will periodically check with You, Your family and Your providers to: re-assess Your current condition; monitor and assess the care You are receiving; determine whether Your Plan of Care continues to be appropriate; and recommend any necessary changes. This re-assessment will occur at least once a year (or more frequently as We determine appropriate) in order to provide You with the required annual Certification and to update Your Plan of Care as needed.

If You choose not to access the Care Coordination Benefit or are receiving care or services outside the 50 United States and the District of Columbia, You must arrange for Your Physician or another Licensed Health Care Practitioner to certify that You are a Chronically Ill Individual and prepare a Plan of Care for You at Your own expense. You must submit all Certifications and Plans of Care to Us. Please see the Claims section of the Policy for more details.

(c) Additional Benefits.

- Additional Stay at Home Benefit. The Additional Stay at Home Benefit can be used to pay for a variety of Your long-term care expenses while You are living in Your Home that are not otherwise covered under the Policy. Additional Stay at Home Services include:

  1. Home Modifications;
  2. Emergency Medical Response Systems;
  3. Durable Medical Equipment;
  4. Caregiver Training; and
  5. Home Safety Check.

  The Additional Stay at Home Lifetime Benefit Amount is equal to 1 times the Long-Term Care Benefit Amount if the monthly option is chosen or 30-times the Long-Term Care Benefit Amount if the daily option is chosen. Benefits paid under the Additional Stay at Home Benefit will reduce the Policy Limit. You do not have to satisfy the Elimination Period to receive benefits under the Additional Stay at Home Benefit. The days for which You receive only the Additional Stay at Home Benefit do not count toward the Elimination Period. You may receive benefits under the Long-Term Care Benefit while receiving benefits under the Additional Stay at Home Benefit.

- Alternate Services Benefit. The Alternate Services Benefit allows You to use Your Policy's benefits to cover long-term care services not expressly covered by the Policy. Such services must be less expensive than the amount We would otherwise pay for such long-term care services. The Alternate Plan of Care as well as the benefit levels to be payable, must be agreed upon by You and Us.

(d) Eligibility for Payment of Benefits. You are eligible for benefits under this Policy if You are a Chronically Ill Individual. A Chronically Ill Individual means that You:

- are unable to perform without Substantial Assistance from another individual at least two Activities of Daily Living due to the loss of functional capacity for a period expected to last 90 days; or
- require Substantial Supervision to protect Yourself from threats to health and safety due to the presence of a Cognitive Impairment.

Activities of Daily Living mean the following activities: bathing, continence, dressing, eating, toileting, and transferring.

Cognitive Impairment means a deficiency in a person's short-term or long-term memory; orientation as to person, place, and time; deductive or abstract reasoning; or judgment as it relates to safety awareness.

(e) Conditions. To receive benefits under this Policy:

- Your Elimination Period must have been satisfied unless otherwise provided in this Policy;
- You must receive covered care or services while this Policy is in effect;
- You must receive care or services that are consistent with Your care needs and are covered under this Policy, and specified in the Plan of Care; and
- We must receive a current Plan of Care and written Proof of Loss, both of which are acceptable to Us.

Because this Policy is intended to be tax-qualified under federal law, You must ALSO provide Us with a written Certification from a Licensed Health Care Practitioner that You are a Chronically Ill Individual. The Certification must be renewed and submitted to Us every 12 months

(f) Optional Benefits. You may elect any of the optional benefits listed. You must pay an additional premium for any of the optional benefits elected.

- [SharedCare. The SharedCare Rider allows Your Partner to access benefits under Your Policy if Your Partner first exhausts the available benefits payable under his or her policy. You and Your Partner may both receive benefits under Your Policy at the same time. In no event will We pay benefits that exceed the maximum Policy Limits of both policies combined. Your Partner must also have added an identical SharedCare Benefit Rider to his/her policy naming You as the Covered Person for that policy.

- Enhanced Elimination Period. If You receive Home Health Care for one or more days in a Calendar Week, We will apply seven days toward the satisfaction of Your Elimination Period, except if Respite Care is being received during the Calendar Week. If Respite Care is received during a Calendar Week, only the actual Dates of Service other than Respite Care will be applied toward satisfaction of Your Elimination Period. Please note that there will be no credit of days which occur before Your first Date of Service. (Calendar Week means the seven consecutive day period that begins on Sunday at 12:01 a.m.)

- Zero-Day Elimination Period for Home Health Care and Adult Day Care. We will waive the requirement that you satisfy the Elimination Period if You are receiving Home Health Care or Adult Day Care. The Elimination Period must still be satisfied before benefits are payable under Long Term Care Benefit for confinement in a Nursing Home or an Assisted Living Facility. However, days which the Home Health Care Elimination Period is waived will count toward meeting the facility Elimination Period.

- Nonforfeiture Benefit. If Your Policy lapses because You have not paid the premium within the Grace Period, after being in force at least three years (or one-year if You elect a limited pay option), it will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. In the event that You do not elect the Nonforfeiture Benefit, Your Policy will contain the Contingent Nonforfeiture Benefit provision. The Contingent Nonforfeiture Benefit provides that in the event We increase rates by more than a specified amount shown in the Contingent Nonforfeiture provision, We will provide You with the opportunity to: pay the increased premium, decrease Your benefits to a level supported by Your current premium, or elect the Contingent Nonforfeiture Benefit. Under the Contingent Nonforfeiture Benefit, Your Policy will remain in force with a reduced policy limit equal to the sum of the premiums You have paid. This means that a reduced benefit will be payable instead of the full Policy Limit.]

10. LIMITATIONS AND EXCLUSIONS

In addition to the Conditions to qualify for benefits set forth above, the following limitations and exclusions apply to the Policy.

(a) Exclusions. This Policy does not cover care, treatment or charges:

- for intentionally self-inflicted injury.
- required as a result of alcoholism or drug addiction (unless drug addiction was a result of the administration of drugs as part of treatment by a Physician).
- due to war (declared or undeclared) or any act of war, or service in any of the armed forces or auxiliary units.
- due to participation in a felony, riot or insurrection.
- normally not made in the absence of insurance.
- provided by a member of Your Immediate Family, unless:
  - the family member is one of the following professionals -- a duly licensed registered nurse, licensed vocational nurse, licensed practical nurse, physical therapist, occupational therapist, speech therapist, respiratory therapist, licensed social worker, or registered dietitian; and
  - the family member is a regular employee of a Nursing Home, Assisted Living Facility, Adult Day Care Center or organization which is providing the services;
  - the organization receives the payment for the services; and
  - the family member receives no compensation other than the normal compensation for employees in his or her job category.
- provided outside the fifty United States and the District of Columbia except as described in the International Coverage section of this Policy.

(b) Non-Duplication of Benefits. This Policy will only pay covered charges in excess of charges covered under any of the following:

- Medicare (including amounts not reimbursable by Medicare such as a Medicare deductible or coinsurance amounts).
- any other governmental program (except Medicaid).
- any state or federal workers' compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law.

(c) Charges not Covered. We will not pay for any of the following: Physician's charges; hospital and laboratory charges; prescription or non-prescription medication; medical supplies; durable medical equipment (except as described in the Additional Stay at Home Benefit); transportation; items and services furnished at Your request for beautification, comfort, convenience or entertainment; room and board charges for independent living quarters in a Continuing Care Retirement Community or similar entity; any type of residential upkeep, construction, renovation, or home maintenance (such as painting or plumbing); lawn/yard care; snow removal; or vehicle or equipment upkeep; and charges for care or services which are not included in and/or are inconsistent with Your Plan of Care.

(d) Coordination with Other John Hancock Individual Long-Term Care Insurance Policies. We may reduce benefits payable under this Policy for Long -Term Care Services if We also pay benefits for such services under any other individual long-term care policy issued by Us. This includes policies providing Nursing Home, Assisted Living Facility and/or Home Health Care coverage whether payable on an expense reimbursement, indemnity or any other basis. Benefits will be reduced under this Policy, only when payment under this Policy and all other John Hancock individual long-term care policies combined would exceed the actual amount You incur for Long-Term Care Services. In no event will We pay under this Policy more than the difference between Your actual expenses and the amount payable by Your other policies with Us.

THIS POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG-TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long-term care services will likely increase over time, this Policy includes inflation protection. You may select the inflation protection that best suits Your needs. You should consider whether and how the benefits of this Policy may be adjusted. You may elect CPI Inflation Coverage[, 5% Compound Inflation] or 5% Compound Guaranteed Purchase Inflation Coverage. These options are described at the end of this Outline of Coverage.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

We cover brain disorders with demonstrable organic cause (including Alzheimer's Disease and similar forms of senility and irreversible dementia) that result in a Cognitive Impairment which are diagnosed by a Physician after the Effective Date of Coverage.

13. PREMIUMS

The total premium for Your Policy as well as a breakdown of the premium by base policy/optional benefits are found below.

Annual Premium:	Applicant A	Applicant B
[Base Policy (includes inflation coverage)	$_____	$_____
• Optional Benefits Selected:		
• SharedCare	$_____	$_____
• Enhanced Elimination Period	$_____	$_____
• Zero-Day Elimination Period for Home Health Care & Adult Day Care	$_____	$_____
• Nonforfeiture	$_____	$_____
Total Annual Premium	$_____	$_____
	Your premium will be $ _____ on a _____ basis.**	Your premium will be $ _____ on a _____ basis.**]

** You may elect to pay Your premium on an annual, semi-annual, quarterly or monthly basis. Please note that the more often you pay, the higher your premium amount will be per year. Additional premium charges are included for semi-annual, quarterly, and monthly premiums. These charges are called "modal fees". These fees are based upon the following modal factors and are used to determine the premium amount for all payment options. The modal factors are 1.00 for annual, .52 for semi-annual, .2625 for quarterly and .0875 for monthly. To calculate Your approximate total annual premium payment based on Your current policy selection:

- Multiply the "Total Annual Premium" as shown in the box above by the factor associated with Your selected mode of payment, and then
- Multiply that result by the number of payments required in a year based upon Your selected payment mode.

14. ADDITIONAL FEATURES

(a) Issuance of Your coverage may depend upon certain medical information about You. This is generally known as medical underwriting.

(b) This Policy provides added protection against lapse. You may name another person on the application to receive a termination notice 30 days after the premium due date. If Your Policy terminates because You did not pay a premium while You would meet the eligibility requirements for the payment of benefits, it may be reinstated within 5 months of the date of termination if:

- You give Us proof of the Cognitive Impairment or Your inability to perform 2 of the Activities of Daily Living without Substantial Assistance; and
- You pay all the unpaid overdue premiums.

(c) This Policy includes an International Coverage Benefit. The International Coverage Benefit provides that we will pay actual charges incurred for covered Long-Term Care Services up to the International Coverage Benefit for care received outside the United States. The International Coverage Benefit will not be paid in excess of an amount equal to: 365-times the Long-Term Care Benefit Amount if You elected the daily Benefit Amount option; or 12-times the Long -Term Care Benefit if You elected the monthly Benefit Amount option.

(d) You may request an increase or decrease to Your coverage by contacting Us in writing. We will provide you with information and instructions regarding available options.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG-TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG-TERM CARE INSURANCE POLICY OR CERTIFICATE.

INFLATION PROTECTION AVAILABLE FOR YOUR LONG-TERM CARE INSURANCE POLICY

CPI Compound Inflation and Guaranteed Increase Option

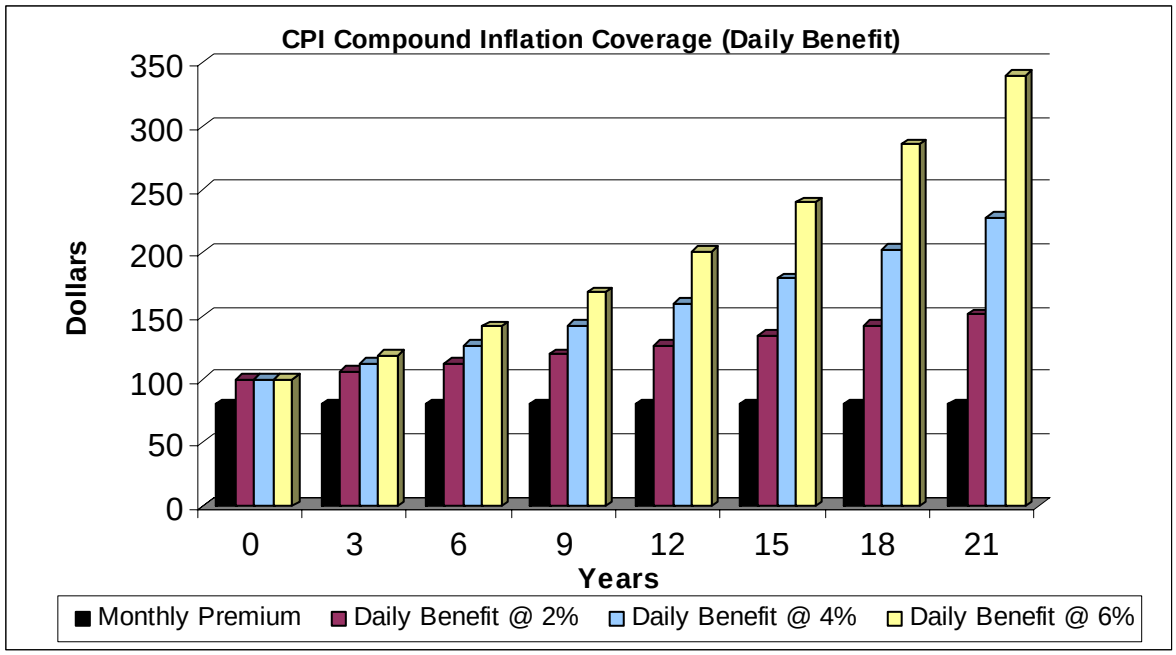
CPI Compound Inflation Coverage: Under this option, Your Long-Term Care Benefit Amount will be increased on each Policy anniversary by the percentage change in the non-seasonally adjusted Consumer Price Index (CPI) three months prior to Your Policy anniversary as compared to the same month's CPI one year prior and rounded to the nearest dollar. In the event the CPI decreases, We will not reduce the Long-Term Care Benefit Amount by such CPI decrease on the Policy anniversary. However, We will offset any such CPI decreases when calculating future CPI increases to the Long-Term Care Benefit Amount. The premium for the CPI Compound Inflation Coverage is included in the Policy premium. Your premium will not change for any annual automatic CPI increase, except as described in the Policy.

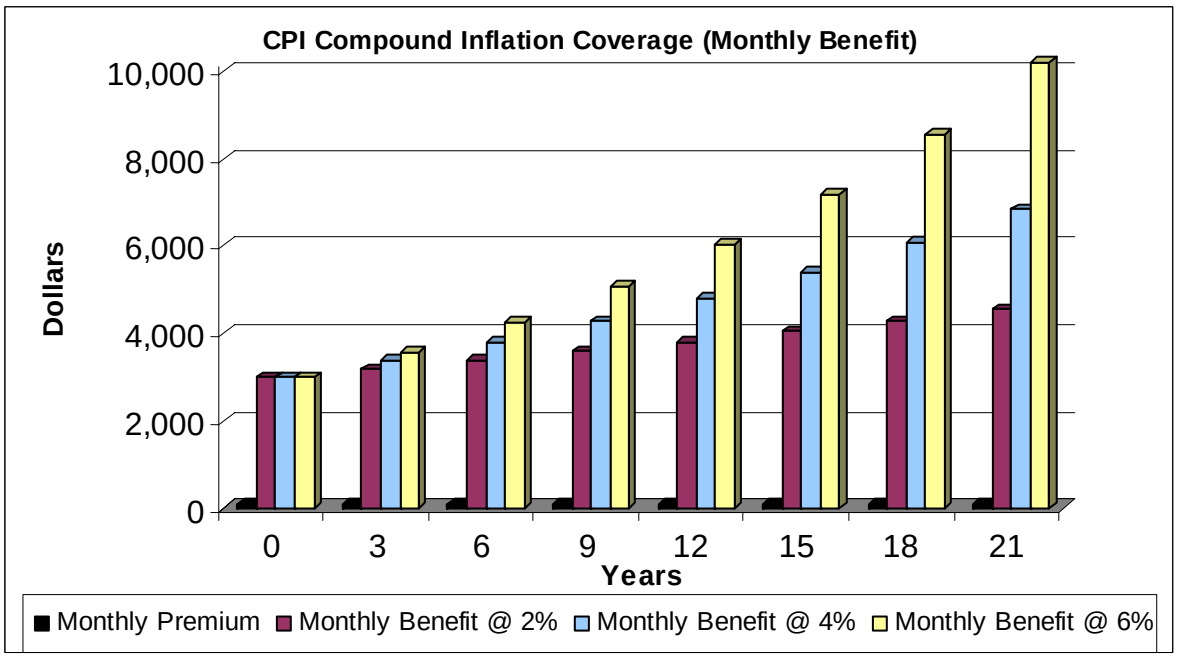
Guaranteed Increase Option: *(Important Notice – The Guaranteed Increase Option is not applicable to You if You are paying Your premium via the Ten-Year Premium Payment Option or the Paid-Up at Age 65 Payment Option.)*

Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), We will offer You the option to increase Your Long-Term Care Benefit Amount by purchasing an additional amount of coverage equal to 10% of the Long Term Care Benefit Amount that was in effect immediately prior to that Option Date. This increase is in addition to the annual automatic CPI increase described above. No additional underwriting will be required. If You elect an increase under the Guaranteed Increase Option, the amount of the annual automatic CPI increase on that Option Date will be based on Your Long Term Care Benefit Amount prior to this additional purchase.

We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire. The premium for any increase under this Guaranteed Increase Option (including any corresponding premium for any optional benefit riders/endorsements that You have elected and are part of Your Policy) will be based on Your age on the Option Date and the premium rates then in effect. The increase on any Option Date will not be available to You (and, if requested, will not take effect) if: any benefits have been payable under Your Policy during the two year period prior to the Option Date; or the Option Date occurs on or after Your 91st birthday.

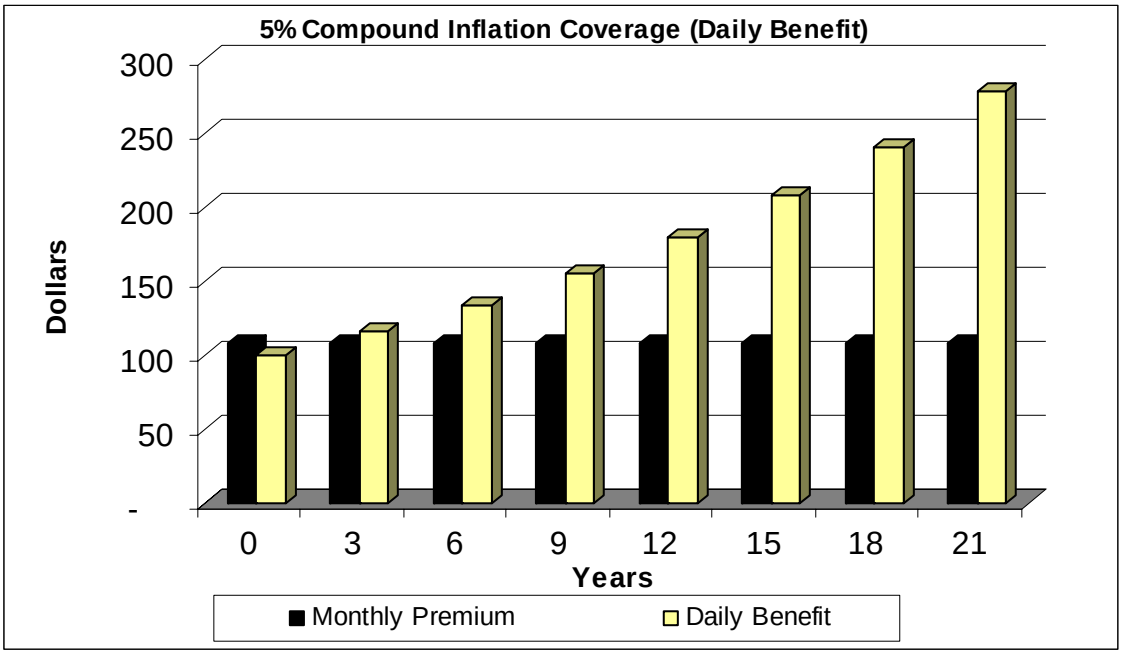
The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under three possible scenarios – increases in coverage assuming a constant 2%, 4% or 6% change in the CPI. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long Term Care Benefit Amount of $3,000 or daily Long Term Care Benefit Amount of $100, and a 3-year Benefit Period.

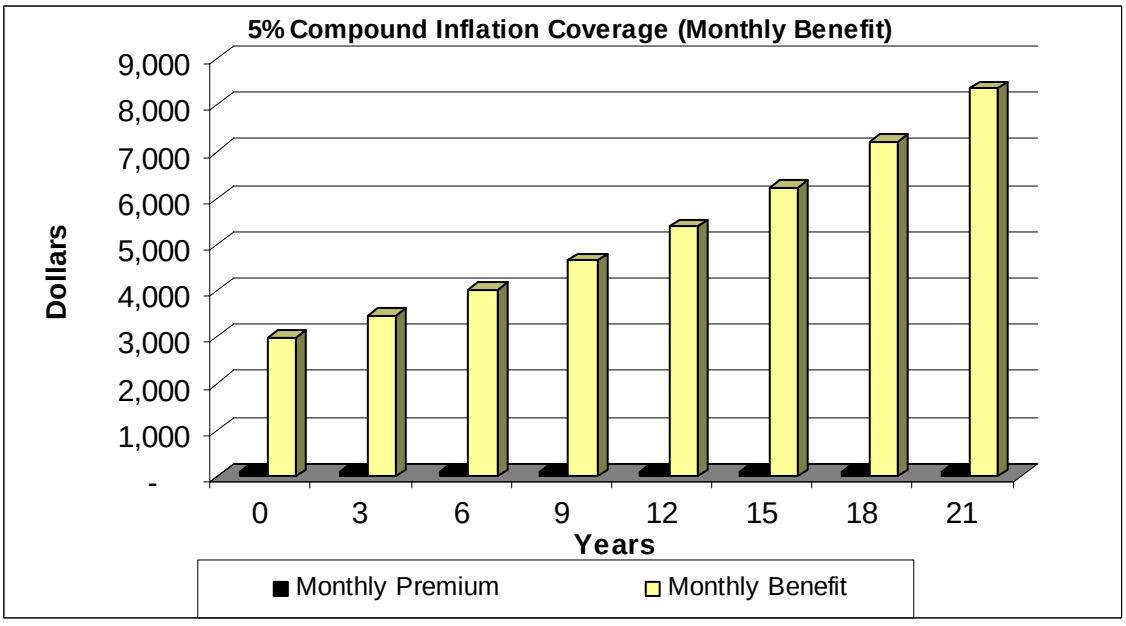




[5% Compound Inflation Coverage. Your Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care Benefit Amount in effect during the prior Policy year. The annual increase is automatic and will occur on each Policy anniversary. The premium for 5% Compound Inflation Coverage is included in the Policy premium. Your premium will not change, except as described in the Policy.

The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under 5% Compound Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 60 and has chosen a monthly Long-Term Care Benefit Amount of $3,000 or daily Long-Term Care Benefit Amount of $100, and a 4-year Benefit Period.



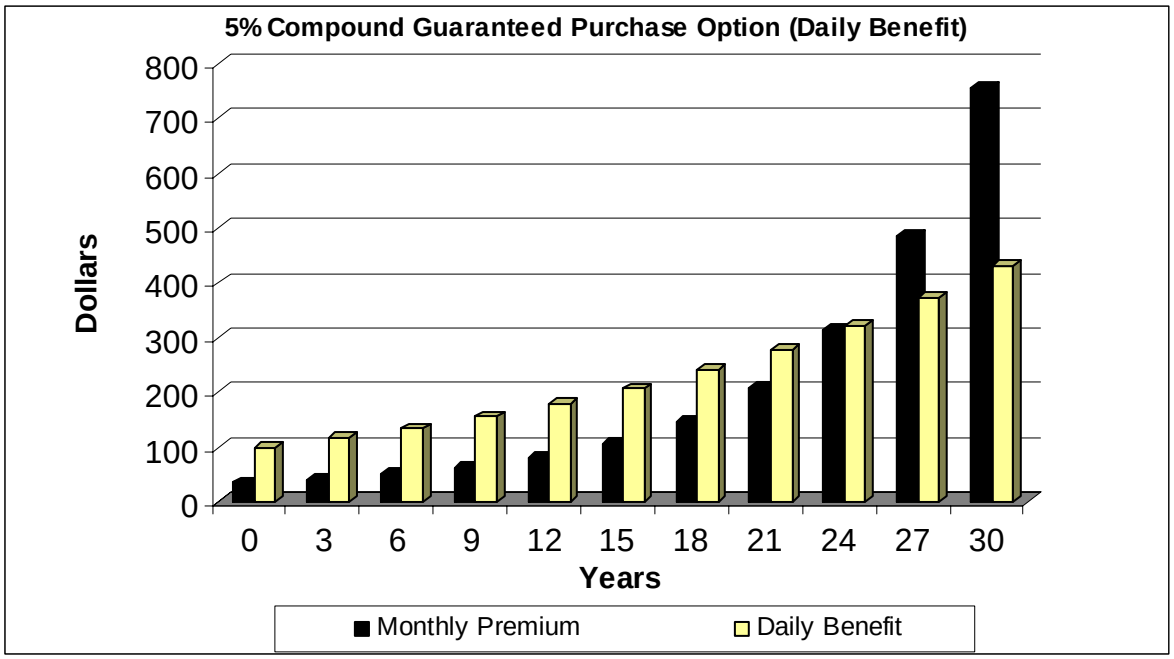


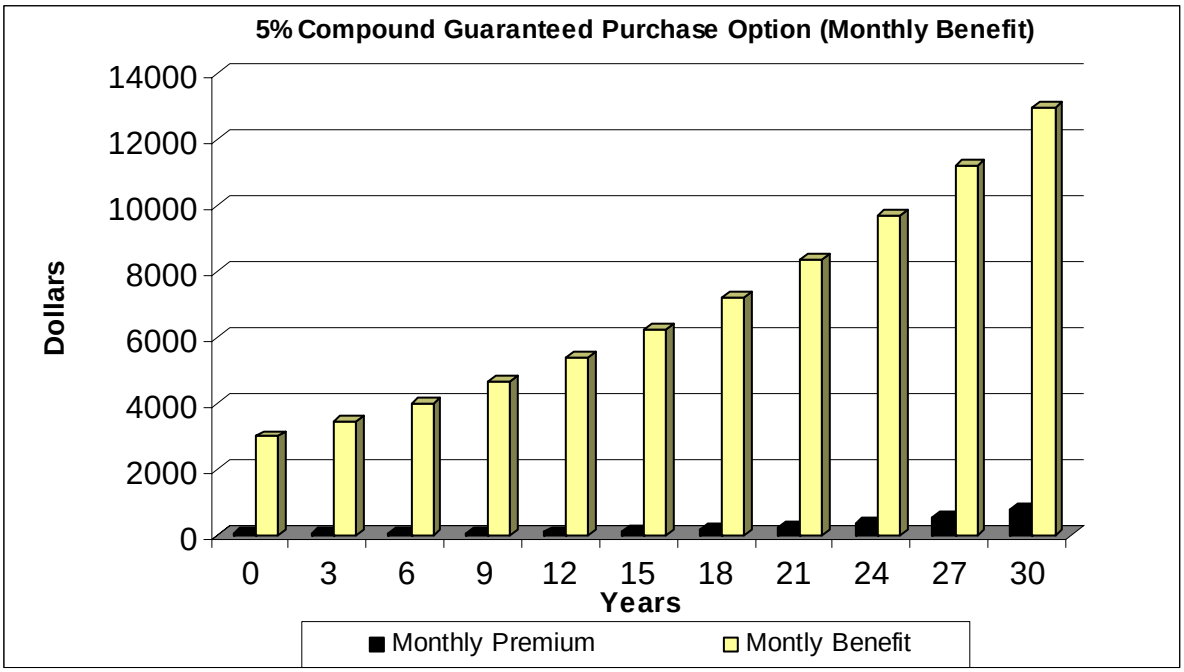
]

5% Compound Guaranteed Purchase Inflation Coverage. Effective as of the third anniversary of the Effective Date of Coverage and every third anniversary thereafter (the "Option Dates"), You may elect to increase Your current Long -Term Care Benefit Amount by 15.8% (5% compounded annually over 3 years) and rounded to the nearest dollar. No additional underwriting will be required. We must receive Your written election within 31-days after the applicable Option Date or Your right to elect that increase will expire.

If You do not elect an increase when offered, that increase will not be available on any future Option Date. You will, however, still have the opportunity to accept future offers unless You decline the offer two times. After You decline the offer of an optional increase on any two Option Dates, no future offers will be available to You. The premium for each increase will be based on Your age on the Option Date and the premium rates then in effect.

The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium if You elect all increases available to You. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long-Term Care Benefit Amount of $3,000 or daily Long-Term Care Benefit Amount of $100, and a 3-year Benefit Period. Assume the person has elected every increase offer.



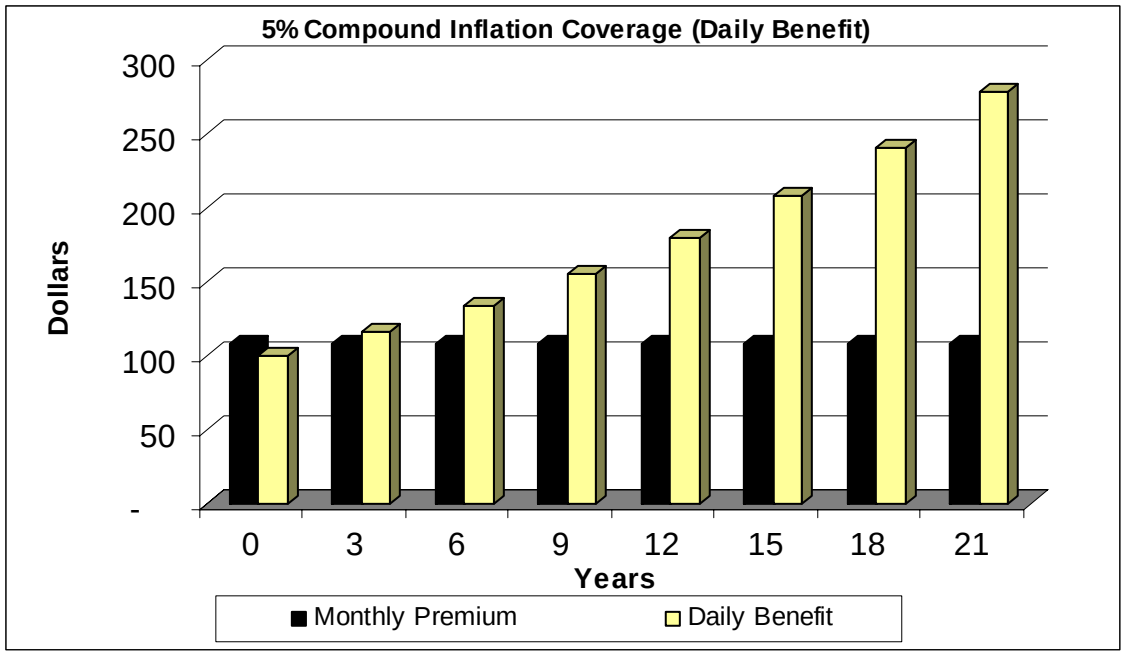


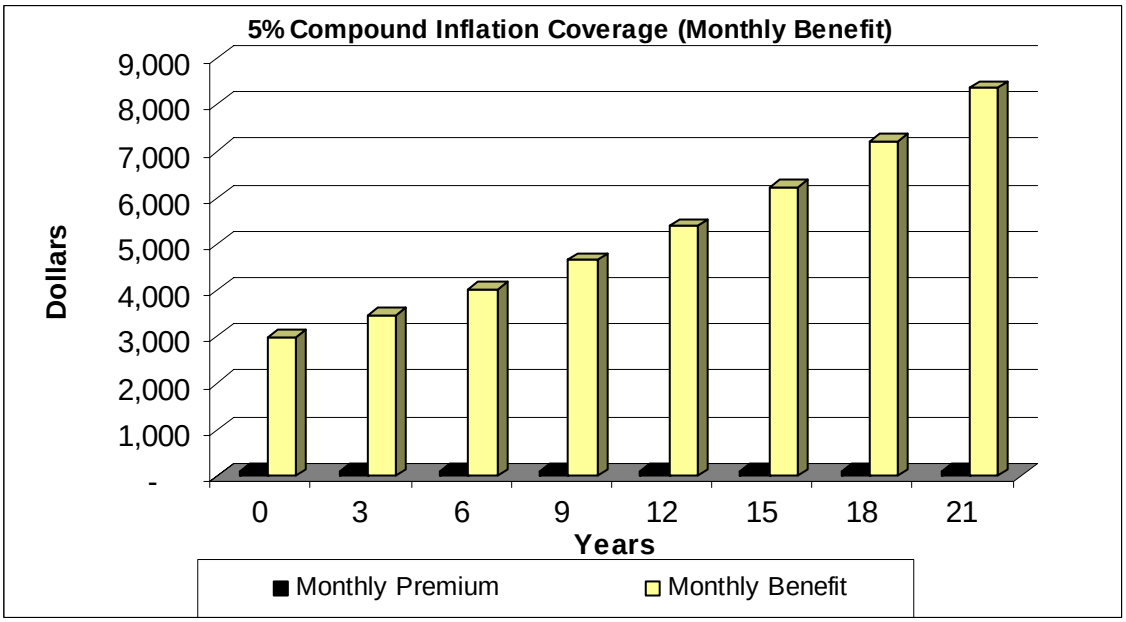
[IMPORTANT NOTICE REGARDING THE AVAILABILITY OF A POLICY WHICH INCLUDES 5% COMPOUND INFLATION PROTECTION

John Hancock also offers a separate policy with the 5% compound inflation option. Please ask Your producer or contact Us for more information if You are interested in learning more about this policy.

Under the 5% Compound Inflation Coverage option, the Long-Term Care Benefit Amount will increase by an amount equal to 5% of the Long-Term Care Benefit Amount in effect during the prior policy year. The annual increase is automatic and will occur on each policy anniversary. The premium for Compound Inflation Coverage is included in the policy premium. The premium will not change, except as described in the policy.

The graphs below show the change in the daily or monthly Benefit Amount and the monthly premium under Compound Inflation Coverage. The graphs illustrate a policy which has been issued to a person who is age 50 and has chosen a monthly Long-Term Care Benefit Amount of $3,000 or daily Long-Term Care Benefit Amount of $100, and a 3-year Benefit Period.


5% Compound Inflation Coverage (Daily Benefit)
Dollars
300
250
200
150
100
50
-
0
3
6
9
12
15
18
21
Years
Monthly Premium
Daily Benefit


5% Compound Inflation Coverage (Monthly Benefit)
Dollars
9,000
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
-
0
3
6
9
12
15
18
21
Years
Monthly Premium
Monthly Benefit

]

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number:	*MULF-126047669*	*State:*	*Arkansas*
Filing Company:	*John Hancock Life Insurance Company*	*State Tracking Number:*	*41708*
Company Tracking Number:			
TOI:	*LTC03I Individual Long Term Care*	*Sub-TOI:*	*LTC03I.001 Qualified*
Product Name:	*Leading Edge - 5% Compound/EEP*		
Project Name/Number:	*/*		

Supporting Document Schedules

Review Status:

Satisfied -Name: Flesch Certification 02/24/2009

Comments:

Attachment:

GenReadCert.pdf

Review Status:

Satisfied -Name: Application 02/24/2009

Comments:

Please see Form Schedule Tab for filed applications:

• Application {LTCAPP09-2 AR}
• Corporate Solutions Application {CORPAPP09 -2 AR}

Review Status:

Satisfied -Name: Outline of Coverage 02/24/2009

Comments:

Please see Form Schedule Tab for filed Outline of Coverage:

• Outline of Coverage {OCLTC-07-2 AR 2/09}

Review Status:

Satisfied -Name: Cover Letter 02/24/2009

Comments:

Attachment:

Cover_letter_AR.pdf

Review Status:

Satisfied -Name: NAIC Transmittal Form 02/24/2009

Comments:

Attachment:

industry_rates_lh_trans.pdf

CERTIFICATION OF READABILITY

State of
Arkansas

Form Number	Flesch Readability Score
LTC-EEP 2/09	40.3
CORP-CPI/GIO 2/09	50.6
LTCAPP09-2 AR	45.0
CORPAPP09 -2 AR	46.0
OCLTC-07-2 AR 2/09	40.7

I certify that to the best of my knowledge and belief, the above-referenced form(s) meet or exceed the readability, legibility, and format requirements of any applicable laws and regulations in the state of Arkansas.

John Hancock Life Insurance Company
Company

Richard Famiglietti
Digitally signed by Richard Famiglietti
DN: cn=Richard Famiglietti, c=US, o=John Hancock Life Insurance Company, ou=Contracts and Legislative Services, email=rfamiglietti@jhancock.com
Reason: I am approving this document
Date: 2009.02.24 12:50:08 -05'00'
Signature

Richard Famiglietti
Name

Sr. Contract Consultant
Title

02/24/2009
Date

CERTIFICATION OF READABILITY

State of

Arkansas

CERTIFICATION OF READABILITY

State of

Arkansas

SUBMIT DATA

John Hancock Life Insurance Company

John Hancock Place
Post Office Box 111 B-6-6
Boston, Massachusetts 02117
1-888-877-6065
Direct: (617) 572-1997
Fax: (617) 572-0399
Email: rfamiglietti@jhancock.com

Richard Famiglietti
Contract Consultant
LTC Contracts and Legislative Services

February 24, 2009

Julie Benafield Bowman
Commissioner
Arkansas Insurance Department
1200 West 3rd Street
Little Rock, Arkansas 72201-1904

Re: **John Hancock Life Insurance Company**
Company NAIC # 65099, FEIN # 04-1414660
Individual Long-Term Care Insurance Forms & Rate Submission
Endorsements Forms for Policy Form LTC-06 AR
(See attached Forms List)

Dear Commissioner:

We enclose copies of the forms listed above for your review and approval. A description of these forms is found below. These forms are new and will replace any prior versions that we currently have on file with your Department. These forms will be used with our Leading Edge policy form LTC-06 AR approved by your Department on 01/08/2007. The effective date for the use of these forms will be July 1, 2009 or immediately following approval if later. The purpose of this filing is as follows:

- *Enhanced Elimination Period Endorsement* – New Endorsement Form LTC-EEP 2/09 enhances the definition of Elimination Period by applying 7-days towards the satisfaction of the Elimination Period when 1-day of Home Health Care is received.

- *CPI Compound Inflation Coverage & Guaranteed Increase Option Endorsement* – Endorsement Form CORP-CPI/GIO 2/09 is identical to our previously approved Automatic Compound Inflation Coverage & Guaranteed Increase Option Endorsement Form LTC-CPI/GPO 6/07, approved by your Department on (date) 12/03/2007, except that we have changed the name of the Endorsement for marketing distribution purposes.

- *5% Compound Inflation Coverage* - We would like to use previously approved Endorsement Form LTC-COMP with Leading Edge policy form LTC-06 AR. This endorsement provides 5% annual compound inflation coverage and was approved by your Department on 03/29/2002.

We are also submitting new applications and outlines of coverage in order to reflect the new filed features described above. Please see application forms: LTCAPP09-2 AR and CORPAPP09 -2 AR. Please see outline of coverage form OCLTC-07-2 AR 2/09.

In addition, we are enclosing a new Actuarial Memorandum to reflect these changes.

From time to time, the shading of the paper color may change to differentiate between different distribution channels or product availability. This upgrade will not affect the text content of any form nor produce an unacceptable or dissimilar print. Finally, approved forms may be viewed/printed via website technology. Variable information is enclosed by brackets "[ ]" please see Appendix A for Statement of Variability.

This submission is being filed simultaneously in all 50 states and the District of Columbia.

Please note that your Department accepted our Partnership Certification for underlying policy form LTC-06 AR approved by your Department on 07/08/2008. We intend to use these new enhancements/forms with this policy and such forms meet all applicable Partnership requirements.

The following items are included in this submission:

- the submission letter
- above referenced forms
- a $200.00 filing fee
- all required certifications.

Thank you for your time and consideration in this matter.

Sincerely,

Richard Famiglietti
Contract Consultant

Forms List

Form Description	Form Number
Enhanced Elimination Period Endorsement	LTC-EEP 2/09
CPI Compound Inflation Coverage & Guaranteed Increase Option	CORP-CPI/GIO 2/09
Application	LTCAPP09-2 AR
Corporate Solutions Application	CORPAPP09 -2 AR
Outline of Coverage	OCLTC-07-2 AR 2/09

Appendix A – Statement of Variability

Application LTCAPP09-2 AR

- Brackets indicate items that may appear as shown or be omitted.
- In Part IV, the full portfolio of benefits is shown on each submitted application. This section is variable to allow for the selection of benefits. For example, we may choose not to offer a particular rider based upon distribution channel. However, we will never offer coverage selections which are less than required by your state.
- Part VI – Certain sections of Part 6 could vary based upon payment options available, administration system or process developed for specific programs or distribution channels. In addition, we may also offer credit card options such as American Express.
- Part X –
    - Item 'f.' will only be included if the portfolio of benefits does not include the 5% Compound Inflation. Part
    - Premium Agreement & Authorization - Item 'd' may be deleted in it's entirety as it is only applicable as it states.
- Part XI – This section would be omitted in Direct Market distribution.
- Part XII - Credit for Application would be omitted in Direct Market channel. In addition, the requested producer information may vary due to administrative platforms used or internal reporting requirements.

Application CORPAPP09-2 AR

- Brackets indicate items that may appear as shown or be omitted.
- Corporate Solutions title would be omitted entirely.
- Part 1 – Agent Use Only information the Underwriting Program information will either be shown or be omitted and the Benefit Tier information will be either 2 or 3 tiers.
- Part 2 –
    - Actively at work question hours per week may vary based on the marketing needs or program features; however, it will never be less than 17.5 hours or greater than 30 hours.
    - Relationship to Employee and the Which Applies to You? section may be omitted based upon the distribution channel, marketing needs or program features offered.
- Part 3 –
    - Simplified Underwriting Program instructions may be omitted based upon the program needs.
    - Section B may be omitted if the program is determined to be simplified underwriting.
- Part 4 - the full portfolio of benefits is shown on each submitted application. This section is variable to allow for the selection of benefits. For example, we may choose not to offer a particular rider based upon distribution channel. However, we will never offer coverage selections which are less than required by your state.
- Part 6 – Certain sections of Part 6 could vary based upon payment options available, administration system or process developed for specific programs or distribution channels. In addition, we may also offer credit card options such as American Express.
- Part 10 – The 2nd bracketed paragraph of item d may be deleted in its entirety. It will either be in or out.
- Part 11 – This section would be omitted in Direct Market channel.
- Part 12 - Credit for Application would be omitted in Direct Market channel. In addition, the requested producer information may vary due to administrative platforms used or internal reporting requirements.

FLESCH SCORE CERTIFICATION

The undersigned, as officer of the John Hancock Life Insurance Company, hereby certifies that each form in this filing meets the Flesch minimum reading ease score of 40.

(Signed by Officer of Company)
Marie Roche
Assistant Vice President
Long-Term Care Compliance

Date: February 16, 2009

Life, Accident & Health, Annuity, Credit Transmittal Document

1.	Prepared for the State of	Arkansas

2.	Department Use Only
	State Tracking ID

3.	Insurer Name & Address	Domicile	Insurer License Type	NAIC Group #	NAIC #	FEIN #	State #
	John Hancock Life Insurance Company P. O. Box 111 Boston, MA 02116	MA	Life & Health	356	65099	04-1414660	

4. Contact Name & Address	Telephone #	Fax #	E-mail Address
Richard Famiglietti 200 Berkeley Street, B-6-06 Boston, MA 02116	888-877-6075	617-572-0399	rfamiglietti@jhancock.com

5.	Requested Filing Mode	☒ Review & Approval ☐ File & Use ☐ Informational ☐ Combination (please explain): _____ ☐ Other (please explain): _____

6.	Company Tracking Number	SERFF Filing # MULF-126047669
7.	X New Submission ☐ Resubmission	Previous file # _____
8.	Market	X Individual ☐ Franchise Group: ☐ Small ☐ Large ☐ Small and Large ☐ Employer ☐ Association ☐ Blanket ☐ Discretionary ☐ Trust ☐ Other: _____
9.	Type of Insurance	LTC03I.Individual Long Term Care
10.	Product Coding Matrix Filing Code	LTC03I.001 Qualified
11.	Submitted Documents	X FORMS ☐ Policy ☒ Outline of Coverage ☐ Certificate ☒ Application/Enrollment ☒ Rider/Endorsement ☐ Advertising ☐ Schedule of Benefits ☐ Other Rates ☒ New Rate ☐ Revised Rate ☐ FILING OTHER THAN FORM OR RATE: Please explain: _____ SUPPORTING DOCUMENTATION ☐ Articles of Incorporation ☐ Third Party Authorization ☐ Association Bylaws ☐ Trust Agreements ☐ Statement of Variability X Certifications ☒ Actuarial Memorandum ☐ Other_____

12.	**Filing Submission Date**	**2/24/2009**			
13	**Filing Fee (If required)**	Amount $200.00		Check Date	EFT Submission
		Retaliatory ☒ Yes ☐ No		Check Number	EFT Submission
14.	**Date of Domiciliary Approval**	**Pending approval in Massachusetts. Filing submitted in all states and the Arkansas.**			
15.	**Filing Description:**				

Re: John Hancock Life Insurance Company
Company NAIC # 65099, FEIN # 04-1414660
Individual Long-Term Care Insurance Forms & Rate Submission
Endorsements Forms for Policy Form LTC-06 AR
(See attached Forms List)

Dear Commissioner:

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• CPI Compound Inflation Coverage & Guaranteed Increase Option Endorsement – Endorsement Form CORP-CPI/GIO 2/09 is identical to our previously approved Automatic Compound Inflation Coverage & Guaranteed Increase Option Endorsement Form LTC-CPI/GPO 6/07, approved by your Department on (date) 12/03/2007, except that we have changed the name of the Endorsement for marketing distribution purposes.

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We are also submitting new applications and outlines of coverage in order to reflect the new filed features described above. Please see application forms: LTCAPP09-2 AR and CORPAPP09 -2 AR. Please see outline of coverage form OCLTC-07-2 AR 2/09.

In addition, we are enclosing a new Actuarial Memorandum to reflect these changes.

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16. Certification (If required)

I HEREBY CERTIFY that I have reviewed the applicable filing requirements for this filing, and the filing complies with all applicable statutory and regulatory provisions for the Arkansas.

Print Name **Richard Famiglietti** Title **Contract Consultant**

Signature Date: **2/24/2009**

17.	Form Filing Attachment
This filing transmittal is part of company tracking number	
This filing corresponds to rate filing company tracking number	

	Document Name Description	Form Number		Replaced Form Number Previous State Filing Number
01	CPI Compound	CORP-CPI/GIO 2/09	X Initial ☐ Revised ☐ Other _____	
02	Enhanced Elimination Period	LTC-EEP 2/09	☒ Initial ☐ Revised ☐ Other _____	
03	Corporate Solutions Application	CORPAPP09-2 AR	☒ Initial ☐ Revised ☐ Other _____	
04	Leading Edge Application	LTCAPP09-2 AR	☒ Initial ☐ Revised ☐ Other _____	
05	Outline of Coverage	OCLTC-07-AR 2/09	☒ Initial ☐ Revised ☐ Other _____	
06			☐ Initial ☐ Revised ☐ Other _____	
07			☐ Initial ☐ Revised ☐ Other _____	
08			☐ Initial ☐ Revised ☐ Other _____	
09			☐ Initial ☐ Revised ☐ Other _____	
10			☐ Initial ☐ Revised ☐ Other _____	
11			☐ Initial ☐ Revised ☐ Other _____	

18.	Rate Filing Attachment			
This filing transmittal is part of company tracking number				
This filing corresponds to form filing company tracking number			**N/A**	
Overall percentage rate indication (when applicable)				
Overall percentage rate impact for this filing			**%**	
	Document Name **Description**	**Affected Form Numbers**		**Previous State Filing Number**
01	**Actuarial Memorandum and Certification for LTC-06 AR**	**LTC-06 AR**	☒ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _Addendum____**	
02			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
03			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
04			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
05			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
06			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
07			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
08			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
09			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	
10			☐ **New** ☐ **Revised** **Request +____% -____%** ☐ **Other _____**	

LH RFA-1

